Attachment 1

HEALTH PROMOTION AND COMMUNICATION PROGRAM

SCOPE OF WORK

I. Introduction

A. Purpose

The purpose of this task order is to assist selected Local Government Units (LGUs) in the Philippines through the Department of Heath (DOH) and related agencies to broaden the reach, improve the quality and sustain health promotion and communication efforts to increase appropriate healthy behaviors and practices and consequently improve the health status of the Filipinos. The implementation of the Health Promotion and Communication Program shall support and strengthen the capacity of in-country institutions to implement effective evidence-based health promotion and communication activities and includes: (a) analysis of information needs for desired behavior change outcomes and marketing appropriate health services; (b) developing and evaluating appropriate interventions and approaches for health promotion and communication; (c) developing appropriate support tools and materials; (d) designing and conducting relevant training and other capacity-building activities; (e) ensuring the integration of sustainable health promotion and communication activities in the broader health sector programming by in-country institutions at all levels; (f) ensuring that technical support for health promotion and communication is provided as part of the comprehensive technical assistance package provided to program partners and stakeholders; (g) supporting and strengthening the capacity of local institutions to undertake and publish related research studies and carry out the various aspects of health promotion and communication technical work; (h) coordinating and providing technical assistance to health promotion and communication activities of other USAID-assisted projects; and (i) providing other support services and technical assistance that is needed to achieve the expected results described in Section III herein. The program shall cover the cities and municipalities of all the provinces under the Autonomous Region in Muslim Mindanao (ARMM) and the illustrative twenty-three (23) priority provinces under the HealthGov (Health Systems Development Project), the primary LGU health assistance activity supported by USAID/Philippines. HIV/AIDS interventions shall cover the six identified priority zones, as follows: Clark Development Zone, Metro Manila, Metropolitan Cebu, Iloilo-Bacolod area, Davao-General Santos corridor, and Zamboanga City.

B. Challenges and Opportunities

Despite some health gains in recent years, the Philippines continue to face significant health challenges. Its fertility rate is the third highest in Southeast Asia and use of modern methods remains low. Majority of births are high risk and rate of induced abortion is high. A significant percentage of deliveries are not assisted by trained health professionals. Little progress has been made in reducing malnutrition in children under five and immunization rates have been declining. Not surprisingly, infant mortality is still relatively high (29 per 1000 live births per year). Every day, 75 Filipinos die of tuberculosis (TB) making TB the sixth most common cause of deaths in the Philippines. HIV-AIDS seroprevalence rate remains low (below 1%); however, increasing incidence of infections has been reported among certain high risk groups pointing to the need for continuing education in HIV-AIDS prevention. There is also the threat of entry of avian influenza into the country which could result in economic loss and loss of human lives. Notwithstanding efforts to improve the provision of health services, wide disparities in health status continue to exist among Filipinos by sex, location, education and economic class. Many of these health concerns are due to lack of information. While admittedly, health promotion and communication alone cannot change these situations; it cannot be denied that it has an essential and integral part to play in an effective response to current health problems.

Significant proportions of women, men and children; the poor, the less educated and those residing in rural and marginalized communities continue to demonstrate unhealthy behaviors and practices that could be corrected by appropriate and effective health promotion and communication interventions. Many of these health concerns are due to lack of information, cultural practices and environments not conducive to healthy behaviors. People need to know about healthy practices, where to go for health services, national and local health policies that affect them, and the health

situation in the country and in their localities. The vulnerable groups, such as those cited above, need appropriate communication approaches and tools that are especially tailored to their cultural and socio-economic situation.

Major challenges in health promotion and communication intended for behavior change include, among others:

- Limited ability by in-country institutions to plan, implement and evaluate effective health promotion and communication activities;
- Health promotion and communication efforts appear to be fragmented, vertical, often focused on single health content, do not often show evidence of audience analysis, and make limited use of persuasive approaches;
- Limited contacts between clients and information providers including health care personnel; survey results show minimal contact between clients and health care providers and a lot of missed opportunities for interpersonal communication and counseling;
- Sub-optimal use of the mass media, which is often utilized as a stand alone communication strategy;
- Absence of effective health promotion and communication strategies that are community-based, theory-driven, and use multiple interpersonal and mediated channels to reach the target population;
- The need to improve the quality of health promotion and communication approaches, tools and materials; and
- Difficulty sustaining health promotion and communication efforts.

It takes time to change behavior. Interpersonal communication (IPC) has long been recognized by experts as the key element in bringing about desired behavior change in people. This is because IPC allows adaptation to local conditions and enables interaction between clients and information providers, hence, is better able to address individual client's needs. On the other hand, mass media is effective in promoting healthy practices, disseminating information on health services and is essential for shifting social and cultural norms. A strong health promotion and communication program would generally use both. Due to various reasons that include, among others, inadequate resources for community outreach activities brought about by the devolution of health services in the Philippines, lack of training on interpersonal communication among service providers and high cost of mass media campaigns, there is difficulty in sustaining both interpersonal communication and mass media interventions.

C. Implementation Strategies

The Contractor shall utilize two main health promotion and communication strategies: (1) interpersonal communication and counseling; and (2) public information through the use of mass media to effect behavior change. Interpersonal communication shall be the primary strategy and mass media shall be used to support interpersonal communication. To expand and sustain health promotion and communication activities, the program shall strengthen and support community mobilization and participation and capacity building of community-based volunteers and local institutions.

Under the program, priority LGUs covered under the HealthGov and the SHIELD ARMM Health Projects are expected to be the primary target beneficiaries and shall be the lead implementers of health promotion and communication activities at the local level. Health educators and service providers shall continue to carry out interpersonal communication activities with clients. The Contractor shall assist LGUs augment the current network of health information providers by introducing tested strategies for mobilizing and building the capacity of community-based volunteers to conduct interpersonal communication and peer counseling. Community volunteers could include champions like satisfied family planning acceptors and successfully treated TB patients. The Health Promotion and Communication Program shall maximize opportunities for increasing the reach and enhancing the quality of interpersonal communication and counseling at the community level and in health facilities.

Another level of interpersonal communication that shall be carried out under the program is dialogue with national and local policy makers. This shall be undertaken by champions like local health service providers, other local officials, and leaders of civil society groups. The engagement of the Health Promotion and Communication Program for this specific task shall focus on packaging of appropriate tools and materials and developing the presentation skills of champions.

It is expected that public information on health, disseminated through mass media will increase awareness and knowledge on appropriate healthy behaviors and will support other communication strategies such as community mobilization and

interpersonal communication. It is also expected that mass media interventions related to health promotion will influence positive health-seeking behaviors among target audiences, particularly those who are not reached by interpersonal communication.

The programmatic scope of the Health Promotion and Communication Program includes the following elements as identified in the current Foreign Assistance Reform framework: HIV-AIDS, tuberculosis, avian influenza, maternal and child health, and family planning and reproductive health.

Interpersonal communication intensified through community participation and the mass media shall be utilized to disseminate persuasive information on healthy practices, health services and other support information and ultimately increase demand and utilization of health services among the various project target groups. Hygiene messages, particularly in so far as they impact on maternal and child health and nutrition, and prevention of major infectious diseases shall be incorporated, as appropriate. For national and local policymakers, information on the health sector policy environment shall be disseminated. This shall include information on the health situation and status of important health indicators, the interrelationships of the population issue to environment and other sectoral development concerns, current national and local health policies and gaps in the effective implementation of these policies.

The outcome of health promotion and communication interventions directed to consumers is the increased number of individuals practicing healthy behaviors. Improved healthy behaviors of individuals as maybe influenced by change agents like community volunteers shall lead to improved health practices for the family. Community level change shall occur as more families embrace healthy behaviors which then sums up to favorable outcomes at national aggregate levels. On the other hand, the communication interventions to policymakers is expected to generate support for health programs in general including support for health promotion and communication activities through appropriate policies and health financing, all of which shall support the increased practice of healthy behaviors in the population. For some specific health concerns, certain provinces may need to be provided more intensified support and attention. Annex 2 shows the Health Promotion and Communication Project conceptual framework described above.

Subsumed under the communication strategies above is the enhancement of the quality and range of health promotion and communication approaches, the necessary support tools as well as mass media materials. The Contractor shall ensure that health promotion and communication approaches and tools are (a) audience-centered; and b) integrate various health content areas, where appropriate to ensure a holistic response to the information and health needs of clients.

The strategy on capacity building of local institutions under the program shall be pursued to ensure institutionalization and sustained health promotion over time. Under this strategy, the Contractor shall mobilize and build the capacity of local institutions and individuals to help LGUs and other local partners in institutionalizing; as well as in designing, implementing, monitoring and evaluating sustainable, integrated and audience-centered health promotion and communication interventions and activities. Potential partners under this strategy include health educators and communication officers of the DOH, POPCOM, and LGUs; local universities, media and professional organizations, private service providers, private companies like broadcast institutions; and civil society groups. The Contractor shall build linkages with the above-mentioned potential partners at the local and national levels and some may become sub-partners of the program, as appropriate.

Cooperation with other USAID projects is an essential aspect of all the components. USAID will manage its health program in the Philippines in such a way as to obtain the best collective contribution of all the projects to the Strategic Objective indicators. The Contractor shall work in close collaboration with other projects. These relationships between projects will be based on a client-partner principle under which, in a given area for cooperation, one partner project will take on the role of a ‘client’ - e.g., helping to identify the health information needs of LGU service providers and local communities, identifying national policy issues, or defining outcomes of most benefit to the Philippines, while the other partner project will act more as an implementing partner - e.g., delivering a well-defined approach for responding to identified information needs; or providing highly specialized technical expertise. The Contractor shall help form these relationships with other programs and projects, as needed.

D. Link to Strategic Plan, Results Framework and Mission Goals

The Mission's Strategic Objective (SO) 3: Improved Family Health Sustainability Achieved has four Intermediate Results (IRs). These are:

IR 1: LGU provision and management of health services strengthened;
IR 2: Provision of quality services by private and commercial providers expanded;
IR 3: Appropriate healthy behaviors and practices increased; and
IR 4: Policy environment and financing for provision of health services improved.

The Health Promotion and Communication Program shall be the lead health promotion and communication activity under SO 3 and shall be primarily responsible for achieving IR 3. Specifically, it shall support IR 1 primarily through assisting LGUs to enhance the levels of healthy practices and behaviors particularly among the poor as well as increasing their access to information on health services. It shall contribute to the success of the expanded private sector project under IR 2 by enhancing the health seeking behavior of Filipinos, in general and informing target populations of the availability of health services and products not just in the public sector but in the private sector, as well. IR 4 shall support the enactment of appropriate policies and provision of financing for health programs including health promotion and communication activities. Relative to this, the Health Promotion and Communication Program shall provide technical assistance in the effective use of interpersonal communication as a strategy for generating support from national and local policy makers. Specifically, technical assistance on advocacy from this program shall focus on packaging presentation materials and enhancing presentation skills of program advocates and champions.

The current SO 3 results framework is in Annex 1.

II. OBJECTIVES

A. Program Objectives

The Health Promotion and Communication Program aims:

1) To promote healthy behaviors and practices - especially in family planning (FP), maternal and child health (MCH) and nutrition, tuberculosis (TB), HIV-AIDS and other infectious diseases like avian influenza (AI) - through the provision of technical assistance in the development and implementation of more extensive and effective health promotion and communication interventions by appropriate/mandated agencies and institutions;
2) To mobilize and strengthen the capacity of appropriate national and local institutions, organizations and individuals to provide technical assistance to local health implementers in the design, implementation, monitoring and institutionalization of sustained and high quality health promotion and communication activities; and
3) To promote high quality and effective health promotion and communication initiatives among USAID cooperating agencies by ensuring that health promotion and communication is part of the comprehensive technical assistance package made available to LGUs and other program partners.

B. SO 3 and IR Level Performance Indicators

As the primary activity under IR 3, the Health Promotion and Communication Program is expected to contribute, albeit indirectly, and support the achievement of impact indicators for SO3 and the Foreign Assistance Reform health program, such as:

HIV-AIDS
1. Number of HIV infections prevented by USG assistance

Tuberculosis (TB)
2. TB treatment success rate

Maternal and Child Health (MCH)
3. Under-five mortality
4. Percent of deliveries assisted by doctor, nurse or trained midwife

5. Immunization rate

Family Planning and Reproductive Health

6. Number of children born per woman
7. Contraceptive prevalence rate

Policy and Financing

8. Percent of GDP spent on health
9. Public expenditure on health

It is also expected to support and contribute to the achievement of performance indicators for SO 3's three (3) other intermediate results. An illustrative list of these indicators for the various program elements covered in this task order includes:

HIV-AIDS

1. Number of individuals trained to promote HIV/AIDS prevention programs through other behavior change beyond abstinence and/or being faithful, with USG assistance;
2. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful, with USG assistance;
3. Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment;
4. Number of individuals trained in counseling and testing according to national and international standards;

Tuberculosis

5. Case notification rate in new sputum smear positive pulmonary TB cases in USG supported areas;
6. Number of people (medical personnel, laboratory technicians, health workers, community workers, etc.) trained in DOTS with USG funding;
7. Percent of LGUs with at least one PhilHealth accredited DOTS facility;
8. Percent of private health facilities accredited as DOTS facility;

Avian Influenza (AI)

9. Number of people trained in AI prevention;
10. Number of people trained in AI-related knowledge and skills;
11. Number of LGUs (including barangays) with AI preparedness plans developed;
12. Estimated number of individuals reached through mass media, IEC and community outreach AI awareness and behavior change programs;
13. Number of barangays implementing community based early warning systems for: (a) animal infections; and (b) human infections;
14. Number of LGUs benefiting from public-private partnerships on AI prevention activities;

Maternal and Child Health

15. Number of pregnant women with at least four antenatal care (ANC) visits by skilled providers from USG-assisted facilities;
16. Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal/newborn health through USG-supported programs;
17. Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in a child health and nutrition (including breastfeeding) through USG-supported health programs;
18. Number of children less than 12 months of age who received DPT3 (as proxy to FIC) in a given year from USG-supported programs;
19. Number of children under 5 years of age who received Vitamin A from USG-supported programs;
20. Number of cases of child diarrhea treated in USG-assisted programs;
21. Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs;

22. Percent of fully immunized children;
23. Number of products with Sangkap Pinoy seal;

Family Planning and Reproductive Health

24. Couple years of protection (CYP) in USG-supported programs;
25. Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in FP/RH with USG funds;
26. Number of people that have seen or heard a specific USG-supported FP/RH message;
27. Amount of in-country public and private financial resources leveraged by USG programs for FP/RH;
28. Number of people trained in strategic information management with USG-assistance;
29. Number of counseling visits for FP/RH as a result of USG assistance;
30. Number of service delivery points reporting stock-outs of any commodity offered by the service delivery point;
31. Contraceptive prevalence rate for modern methods among the poor;
32. Percent of family planning users obtaining supplies and services from private sector sources;

Policy and Finance

33. Number of LGUs in USG-supported areas where at least 80% of families have been covered by the Philippine Health Insurance Corporation (PHIC);
34. Number of LGUs in USG-supported areas that increased the share of the health budget over total LGU budget;
35. Percentage increased in the share of the ARMM health budget relative to the total ARMM budget;
36. Number of people covered by USG-supported financing programs;

The Contractor shall assist partners/stakeholders to identify appropriate core messages to be promoted using a holistic approach in responding to clients' health needs with respect to the priority health programs covered in this task order.

III. EXPECTED RESULTS

Activities under the Health Promotion and Communication Program shall lead to the achievement of a set of performance indicators for IR 3 that includes both awareness and behavior change results. The Contractor shall provide appropriate technical assistance to accomplish the following:

A. Awareness Indicators

1. Percentage of most-at-risk individuals for sexually transmitted infections (STIs) who are able to enumerate ways of HIV-AIDS prevention increased by at least 5% annually in USG-assisted sites;
2. Percentage of individuals who are able to identify the symptoms of tuberculosis increased by at least 5% annually in USG assisted sites;
3. Percentage of women citing fear of side effects or health concern as reason for non-use of contraception reduced from 25% in 2004 to 18% by 2011 in USG-assisted sites;
4. Percentage of pregnant women who are able to cite the danger signs of pregnancy and where to go in case of pregnancy complications increased from 57% in 2003 to 70% in 2011 in USG-assisted sites;
5. Percentage of pregnant women who are able to cite the benefits of facility-based delivery assisted by a trained health professional increased by at least 5% annually in USG-assisted sites;
6. Percentage of mothers who are able to cite the benefits and timing of Vitamin A supplementation increased by at least 5% annually in USG-assisted sites;
7. Percentage of mothers who are able to cite samples of fortified food products increased by at least 5% annually in USG-assisted sites;
8. Percentage of mothers who are able to identify the vaccines required by an infant following birth and the correct timing for the administration of these vaccines increased by at least 5% annually in USG-assisted sites;
9. Percentage of mothers who are able to cite the benefits of breastfeeding and appropriate breastfeeding practices increased by at least 5% annually in USG-assisted sites;
10. Percentage of mothers who are able to cite appropriate treatment for child diarrhea increased by at least 5% annually in USG-assisted sites;

11. Percentage of mothers who are able to identify the symptoms of pneumonia increased by at least 5% annually in USG-assisted sites;
12. Percentage of population who are able to describe the proper procedure for hand washing increased by at least 5% annually in USG-assisted sites;
13. Percentage of women who are able to tell where they can access basic health services (e.g., FP, TB, immunization, Vitamin A, low-cost maternity care, pneumonia, and others) increased by at least 5% annually in USG-assisted sites;

B. Behavior Change Indicators

However, since awareness does not necessarily lead to behavior change, the Contractor shall also endeavor to accomplish a set of behavior change indicators, as follows:

1. Percentage of most-at-risk individuals for STIs who sought voluntary counseling and testing increased by at least 5% annually in USG-assisted sites;
2. Percentage of TB symptomatics who voluntarily sought treatment increased from 47% in 2003 to 71% in 2011 in USG-assisted sites;
3. Percentage of pregnant women who sought four or more ante-natal consultations increased from 70% in 2003 to 94% in 2011 in USG-assisted sites;
4. Percentage of pregnant women with a birthing plan increased by at least 3% annually in USG-assisted sites;
5. Percentage of mothers/care givers who sought Vitamin A supplementation services for their children below five years of age increased by at least 5% annually in USG-assisted sites;
6. Percentage of mothers/care givers who consciously provided fortified food products to their children increased by at least 5% annually in USG-assisted sites;
7. Percentage of mothers/care givers who sought immunization services for infants under their care increased by at least 5% annually in USG-assisted sites;
8. Number of couples that discuss the use of contraceptives increased by at least 5% annually in USG-assisted sites;
9. Percentage of men and women endorsing the practice of FP to others increased from 30% in 2006 to 55% in 2011 in USG-assisted sites;
10. Quality of health workers' interpersonal interaction skills improved;
11. Quality of client-provider interactions improved;
12. Client self-efficacy in dealing with health workers increased;
13. Percentage of participating units (public and private) implementing an integrated health information campaign increased by at least 5% annually in USG-assisted sites;
14. Information campaign on avian influenza implemented in at least 80% of all vulnerable/critical LGUS in USG-assisted sites;

The Health Promotion and Communication Program shall take the lead in developing core messages that shall directly support the achievement of the above set of illustrative indicators. However, USAID is also interested in what the Offeror considers as important in terms of making an impact and/or influencing the SO and IR indicators enumerated in Section II.B above. Thus, the Offeror is encouraged to recommend additional project performance indicators on top of those being suggested under this sub-section based on its analysis of the information gaps in the various health program elements covered in this task order.

IV. TASKS AND ACTIVITIES

A. Tasks

The Contractor shall have primary responsibility for promoting healthy behaviors in the general population and potential consumers of health services. Specifically, the Contractor shall undertake the following tasks:

1. Provide technical assistance to program partners in the analysis of information needs for desired behavior change and information dissemination of health services. Assist in developing appropriate core messages to be promoted that have the potential of making the greatest impact on the health indicators identified in Sections II and III based on an in-

depth analysis of the current levels and past trends in the performance of the various program elements covered under this task order and the dynamics surrounding these programs. This process shall include extensive consultations with key program partners at national and local levels. The initial list of core messages may be refined during the course of the project based on the results of qualitative studies on the profiles, perceptions, attitudes and health-seeking behaviors of the various target groups.

2. In consultation with appropriate partners, analyze the health situation and develop health promotion and communication strategies and approaches for the ARMM that takes into consideration the distinct cultural and political nuances of the target populations in the region, as well as the broad strategies and plans of the new ARMM Health Program.

3. Conduct an inventory, document and package for easy and efficient replication effective, inexpensive and sustainable interpersonal communication and counseling approaches for various audiences and groups. Likewise, undertake an inventory and compile samples of relevant existing mass media materials that may be reproduced and utilized by partners, as needed. New materials shall only be developed, if necessary.

4. Enhance the quality and adopt innovations, as appropriate in health promotion and communication approaches, support tools and mass media materials. Review interpersonal communication and counseling processes and content areas to ensure that they adhere to standards and best practices in audience-centered communication. Take the lead in developing an integrated approach to health promotion that takes into consideration the holistic health needs of clients.

5. Make available integrated health promotion and communication strategies and approaches to LGUs and other partners, including appropriate health promotion and communication support tools and materials**.** Provide technical assistance and support the initial implementation of the interventions. The roll-out and production and/or airing of mass media materials shall be carried out by implementing partners with support from appropriate USAID projects.

6. Design integrated training modules on health promotion and communication and conduct appropriate training programs and other capacity-building interventions including mentoring and on-the-job coaching techniques, where relevant, for service providers, local champions and advocates, community volunteers as well as local institutional and individual partners. Technical support for interpersonal communication advocacy activities of champions shall focus on packaging of presentation materials and training on making effective presentations.

7. In collaboration with existing projects, develop a sustainable mechanism for providing technical assistance to LGUs in the planning, implementation, monitoring and evaluation of local health promotion and communication activities as part of the comprehensive technical assistance package made available to LGUs. Ensure the integration of sustainable health promotion and communication activities in the broader health sector programming by in-country institutions at all levels. Identify and establish linkages with appropriate government and non-government institutions at national and local levels that shall be responsible for sustaining and institutionalizing health promotion and communication activities within and outside project sites. Annex 3 presents an illustrative field implementation framework for the HPC Project.

8. Support capacity building of appropriate national, regional and local organizations and individuals to institutionalize and sustain health promotion and communication activities for behavior change including provision of assistance to LGUs and other local partners in health promotion and communication planning, implementation and monitoring and carrying out the various aspects of health promotion and communication technical work.

9. Support generic health communication research to better understand the dynamics involved in behavior change; and operations research to enhance existing or test innovative health promotion approaches and tools. Support and strengthen the capacity of local institutions to undertake health communication research and publish/disseminate/facilitate the utilization of relevant research findings.

10. Develop a Performance Monitoring Plan (PMP) and establish an annual benchmark scale for indicators of achievement of agreed program objectives and indicators. Final and annual benchmarks and targets shall be developed collaboratively and agreed upon between USAID, the Contractor and key partners, including participating LGUs.

11. Collaborate closely with other USAID-supported activities to ensure that technical support for health promotion and communication is provided as part of the comprehensive technical assistance package provided to LGUs and other program partners and stakeholders. Coordinate and provide technical assistance to health promotion and communication activities of other USAID-assisted projects to ensure that appropriate synergies are established between service delivery and health promotion and communication efforts as well as all USAID-supported communication activities to maximize results.

12. Participate in the USAID-organized joint planning and regular coordination and consultation meetings with other contractors and grantees during project implementation. Synchronize areas and schedules for covering priority LGUs and be prepared to provide technical assistance and program resource support for health promotion and communication activities to achieve certain levels of improvements in healthy behaviors and practices in specific project sites. Set up appropriate systems and coordination mechanisms to ensure that all communication tools and materials produced with USAID funding adhere to quality standards and USAID branding requirements.

B. Program Activities

The Health Promotion and Communication Program shall support and strengthen the capacity of in-country institutions to expand the implementation of effective health promotion interventions and information dissemination activities to increase healthy behaviors and practices among Filipinos. The key activities that the Contractor shall undertake and complete are described below. The activities are grouped into three components for efficient organization. For each component, expected outcomes, illustrative activities and component indicators are also reflected.

Component 1: Behavior Change Communication

Under this component, LGUs and other local partners shall be assisted in increasing the reach and improving the quality of behavior change communication interventions which shall include community mobilization for health promotion, interpersonal communication and counseling interventions and appropriate public information dissemination and mass media activities. This shall focus on two levels: (1) community-based through the mobilization of community volunteers and people's organizations; and (2) facility-based which shall encompass public, private and NGO-owned and managed health facilities. Knowledge, attitudes, and skills of community- and facility-based communicators and service providers in the provision of effective interpersonal communication and counseling shall be developed and strengthened. The quality of approaches and tools in interpersonal communication and counseling shall be enhanced and duly disseminated. This shall include approaches, tools and support materials for provider-to-client, peer, individual, couple and group interpersonal communication and counseling.

Under this component, mass media, particularly the radio, shall be used strategically in support of interpersonal communication interventions through (1) integrating content and messages into existing media materials; (2) providing health messages that includes information on types and sources of health services for media dissemination including orientation of media professionals; and (3) technical support on media advocacy to change media content and generate opportunities for inexpensive or free airing of health messages.

The illustrative expected outcomes under this component include:

1. Significant number of service providers and community volunteers mobilized, appropriately trained and regularly conducting interpersonal communication and peer counseling activities in communities and health facilities;
2. Increased number of provider-to-client communication and counseling resulting in greater number of clients demonstrating desired healthy behaviors (e.g., accepting a FP method or going for a pre-natal consultation or TB treatment);

3. Dissemination and implementation of more effective and high quality interpersonal communication and counseling approaches, support tools and mass media materials that are audience-centered and appropriately integrate health-related messages;
4. Scaled up and consistent mass media promotion of desired healthy practices and health services for maximum public health impact;
5. More effective and responsive mass media materials that are audience-centered, integrate appropriate health messages and supportive of interpersonal communication strategies.

The generic illustrative activities are:

1. Documentation and adaptation of best practices and development of innovative interpersonal communication and counseling approaches including appropriate support tools and materials;
2. Development of participatory interpersonal communication and counseling skills training modules and materials for community-based communicators, health service providers and local champions.
3. Inventory and compilation of samples of existing relevant mass media materials; enhancing them, as appropriate; and making them available to national and local partners for replication and mass production;
4. Compilation, regular updating and distribution to local and national media partners, messages on healthy practices, health services and providers, and appropriate health policies;
5. Collaboration with local radio and television stations to develop prototype scripts and formats for radio programs like "mini soaps" that carry health messages; and for creative integration of key health messages in existing popular national and local radio and television programs.

Illustrative indicators associated with these activities are:

1. Number of clients reached in provider-client and peer counseling sessions;
2. Proportion of clients covered in individual and group counseling sessions adopting desired behaviors and practices;
3. Knowledge, attitudes and counseling skills of community volunteers and service providers improved;
4. Number of community volunteers actively providing peer counseling;
5. Range of interpersonal communication and counseling approaches, tools, and materials enhanced and packaged for wider dissemination;
6. Estimated number of target audience reached in mass media and public information dissemination activities;
7. Percent of audience reached through mass media and public information dissemination activities who correctly recall appropriate health messages;
8. Number of media practitioners mobilized for public dissemination of health messages;

Component 2: Institutional Development and Capacity Building for Sustained Health Promotion and Communication

Under this component, the Contractor shall stimulate sustainability of community- and facility-based health promotion and health information dissemination efforts through LGUs. It shall identify strategic structures, organizations and individuals relative to this task and strengthen appropriate national, regional and provincial institutions or individuals that can provide technical support to local government units and other local partners in institutionalizing health promotion and BCC interventions. This component shall likewise provide a strategy for ensuring sustainable capacity-building for LGUs and national/regional/local support agencies including replicating agents/institutions. The Contractor shall provide technical assistance to program partners to generate public and private sector resources for health promotion and communication activities. This technical assistance shall be limited to packaging presentation materials and enhancing presentation skills. It shall document cost-effective and sustainable community-based health promotion and communication strategies, tools and materials for wider dissemination. Operations research to strengthen existing health promotion and communication strategies or test new ones may be supported.

Illustrative expected outcomes under this component include:

1. Increasing amount of public and private sector resources provided for health promotion and communication interventions;

Attachment 3

CLIENT AUTHORIZATION LETTER

Date:

SUBJECT: Past Performance Evaluation

Dear Client:

We are currently responding to the USAID/Philippine's Request for Proposal Task Order Proposal (RFPTOP) # 492-07-03 for the Health Promotion and Communication Project. USAID/Philippines is considering past performance as a source selection factor. As such, a requirement of this response is that past clients of ours be identified and participate in the evaluation process. You are hereby authorized to respond to this and other inquiries.

We have identified Mr./Ms._____ of your organization as the point of contact based on his/her knowledge concerning our work.

Please complete the enclosed Contractor Performance Report Form and forward it directly to USAID/Philippines,---------- ATTN: Elvie Dela Cruz, Acquisition. E-mail responses are encouraged and may be sent to the following address: ecruz@usaid.gov

A response to this questionnaire is requested to the above address no later than February 20, 2007.

Your cooperation is appreciated. Any questions may be directed Ms. Dela Cruz.

Sincerely,

Enclosure

CONTRACTOR PERFORMANCE REPORT INSTRUCTIONS

Block 1: Contractor Name and Address. Identify the specific division being evaluated if there is more than one.

Block 2: Contract number of contract being evaluated.

Block 3: Contract value shall include base plus options. If funding was increased or decreased during the evaluation period, the value in this block should reflect the change.

Block 4: Contract award date and anticipated or anticipated contract completion date.

Block 5: Type of Contract: Check all that apply.

Block 6: Provide a brief description of the work being done under the contract and identify the key performance indicators. This description will allow agencies calling for reference checks to compare statements of work.

Block 7: Circle rating in far right column and provide brief narrative for each of the categories rated. Indicate the contract requirements that were exceeded or were not met by the contractor and by how much. Also calculate the mean score of the ratings.

Block 8: List the names and employment dates of the contractor's key personnel. This will provide a record of how long these managers worked on the contract. If there were many changes in these managers a second page may be necessary. On the comment/rating line briefly describe the managers performance.

Block 9: If given a choice, please explain why you would or why you would not select the contractor for this contract again.

Block 10: The program office person most familiar with the contractor's performance should sign this block. The rating is a combined program office, contracting officer decision. The contracting officer's signature in block 15, signifies concurrence with this rating and the final rating, if a revised rating is necessary.

Block 11-12: The contractor may provide comments but must sign block 12 to indicate review of the rating.

Block 13: If the contractor and contracting officer are unable to agree on a final rating, an agency review at a level above the contracting officer is required.

Block 14: Adjust the ratings assigned in block 7, if appropriate, based on any comments, rebuttals, or additional information provided by the contractor and, if necessary, by the agency review. Calculate a mean score of the contractor's performance.

Block 15: The contracting officer's signature certifies concurrence with the initial and final ratings.